MONTHLY PREMIUMS*

ZIP CODES: 932, 934-940, 950-953, 956-961

NON-TOBACCO						TOBACCO				
Plan A WM20	Plan F WM24	Plan G WM25	Plan High G WM36	Plan N WM35	Attained Age	Plan A WM20	Plan F WM24	Plan G WM25	Plan High G WM36	Plan N WM35
305.21	423.91	334.45		262.54	**Thru 64**	350.82	487.25	384.42		301.77
122.09	169.57	133.78	48.94	105.02	**65**	140.34	194.91	153.77	56.25	120.71
122.09	169.57	133.78	48.94	105.02	**66**	140.34	194.91	153.77	56.25	120.71
134.29	186.52	147.15	48.94	115.52	**67**	154.36	214.40	169.14	56.25	132.78
139.94	194.36	153.63	50.91	120.60	**68**	160.85	223.40	176.59	58.51	138.62
145.58	202.19	160.11	52.86	125.69	**69**	167.33	232.41	184.03	60.76	144.47
151.21	210.03	166.58	54.82	130.77	**70**	173.81	241.41	191.47	63.01	150.31
156.86	217.86	173.06	56.77	135.85	**71**	180.29	250.41	198.92	65.25	156.15
162.50	225.70	179.53	58.65	140.93	**72**	186.78	259.42	206.35	67.41	161.98
169.32	235.17	187.07	60.56	146.85	**73**	194.62	270.31	215.02	69.61	168.79
176.14	244.65	194.61	62.63	152.77	**74**	202.46	281.21	223.69	71.99	175.59
182.98	254.13	202.15	64.69	158.69	**75**	210.32	292.10	232.36	74.36	182.40
189.80	263.61	209.69	66.92	164.61	**76**	218.16	303.00	241.03	76.92	189.20
196.62	273.08	217.24	69.15	170.53	**77**	226.00	313.89	249.70	79.48	196.01
203.70	282.92	225.05	71.38	176.67	**78**	234.13	325.19	258.68	82.04	203.07
210.77	292.75	232.87	73.57	182.80	**79**	242.27	336.49	267.67	84.56	210.12
217.86	302.58	240.69	75.80	188.94	**80**	250.42	347.79	276.66	87.13	217.18
224.94	312.41	248.51	78.13	195.08	**81**	258.55	359.09	285.64	89.80	224.23
232.01	322.24	256.33	80.52	201.22	**82**	266.68	370.40	294.64	92.55	231.29
240.37	333.84	265.56	82.97	208.06	**83**	276.28	383.72	305.24	95.36	239.15
248.72	345.44	274.79	85.49	214.91	**84**	285.89	397.06	315.85	98.27	247.02
257.07	357.05	284.02	88.10	221.75	**85**	295.49	410.40	326.46	101.27	254.88
265.43	368.65	293.25	90.78	228.59	**86**	305.09	423.73	337.07	104.35	262.74
273.78	380.25	302.47	93.54	235.43	**87**	314.69	437.07	347.67	107.52	270.61
279.26	387.85	308.53	96.39	240.14	**88**	320.99	445.81	354.63	110.80	276.02
284.83	395.60	314.69	99.32	244.94	**89**	327.39	454.72	361.72	114.16	281.54
290.54	403.52	320.99	102.35	249.84	**90**	333.95	463.82	368.95	117.64	287.17
296.34	411.58	327.41	105.46	254.83	**91**	340.62	473.08	376.33	121.22	292.91
302.27	419.81	333.96	108.66	259.93	**92**	347.44	482.55	383.86	124.90	298.77
308.32	428.22	340.64	111.97	265.13	**93**	354.39	492.21	391.54	128.70	304.74
314.48	436.78	347.45	115.36	270.43	**94**	361.47	502.04	399.37	132.60	310.84
320.77	445.52	354.40	118.87	275.84	**95**	368.70	512.09	407.35	136.63	317.06
327.18	454.42	361.48	122.47	281.36	**96**	376.07	522.33	415.50	140.77	323.40
333.74	463.52	368.72	126.18	286.99	**97**	383.61	532.78	423.81	145.04	329.87
340.41	472.79	376.09	130.02	292.72	**98**	391.27	543.43	432.28	149.45	336.46
347.22	482.24	383.61	133.95	298.58	**99+**	399.10	554.30	440.93	153.96	343.20

*See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

MONTHLY PREMIUMS*

ZIP CODES: 919-925, 930-931, 933, 941-943, 945, 947-949, 954-955

NON-TOBACCO						TOBACCO				
Plan A WM20	Plan F WM24	Plan G WM25	Plan High G WM36	Plan N WM35	Attained Age	Plan A WM20	Plan F WM24	Plan G WM25	Plan High G WM36	Plan N WM35
359.08	498.72	393.47		308.87	**Thru 64**	412.73	573.24	452.26		355.02
143.64	199.49	157.38	57.58	123.55	**65**	165.10	229.30	180.90	66.18	142.01
143.64	199.49	157.38	57.58	123.55	**66**	165.10	229.30	180.90	66.18	142.01
157.99	219.44	173.12	57.58	135.90	**67**	181.60	252.23	198.99	66.18	156.21
164.63	228.65	180.74	59.89	141.88	**68**	189.23	262.82	207.75	68.84	163.08
171.27	237.88	188.36	62.19	147.87	**69**	196.86	273.42	216.51	71.48	169.96
177.90	247.09	195.98	64.49	153.84	**70**	204.48	284.01	225.26	74.13	176.83
184.54	256.30	203.60	66.79	159.82	**71**	212.11	294.60	234.02	76.77	183.70
191.17	265.52	211.21	69.00	165.80	**72**	219.74	305.20	242.77	79.31	190.57
199.20	276.67	220.08	71.24	172.77	**73**	228.97	318.01	252.97	81.89	198.58
207.23	287.82	228.96	73.68	179.73	**74**	238.19	330.83	263.17	84.69	206.58
215.26	298.98	237.82	76.11	186.69	**75**	247.43	343.65	273.36	87.48	214.59
223.29	310.13	246.70	78.73	193.65	**76**	256.66	356.47	283.56	90.49	222.59
231.32	321.27	255.57	81.35	200.62	**77**	265.88	369.28	293.76	93.51	230.60
239.64	332.85	264.77	83.97	207.84	**78**	275.45	382.58	304.33	96.52	238.90
247.97	344.41	273.96	86.55	215.06	**79**	285.02	395.87	314.90	99.48	247.20
256.31	355.98	283.17	89.18	222.29	**80**	294.61	409.17	325.48	102.50	255.50
264.64	367.54	292.36	91.92	229.51	**81**	304.18	422.46	336.05	105.65	263.80
272.95	379.11	301.57	94.73	236.73	**82**	313.74	435.76	346.63	108.88	272.10
282.79	392.75	312.43	97.61	244.77	**83**	325.04	451.44	359.11	112.19	281.35
292.62	406.40	323.28	100.58	252.83	**84**	336.34	467.13	371.59	115.61	290.61
302.44	420.05	334.14	103.65	260.88	**85**	347.63	482.82	384.07	119.14	299.86
312.27	433.70	345.00	106.80	268.93	**86**	358.93	498.51	396.55	122.76	309.11
322.09	447.35	355.85	110.05	276.97	**87**	370.22	514.20	409.02	126.49	318.36
328.54	456.30	362.97	113.40	282.52	**88**	377.63	524.48	417.21	130.35	324.73
335.10	465.42	370.23	116.85	288.16	**89**	385.17	534.96	425.55	134.31	331.22
341.81	474.73	377.63	120.41	293.93	**90**	392.88	545.67	434.06	138.40	337.85
348.64	484.22	385.18	124.07	299.80	**91**	400.73	556.57	442.74	142.61	344.60
355.61	493.90	392.89	127.84	305.80	**92**	408.75	567.70	451.60	146.94	351.49
362.73	503.79	400.75	131.73	311.91	**93**	416.93	579.07	460.63	151.41	358.52
369.98	513.86	408.77	135.72	318.15	**94**	425.26	590.64	469.85	156.00	365.69
377.38	524.14	416.94	139.84	324.52	**95**	433.77	602.46	479.24	160.74	373.01
384.92	534.62	425.27	144.08	331.01	**96**	442.44	614.50	488.82	165.61	380.47
392.63	545.32	433.78	148.45	337.63	**97**	451.30	626.80	498.60	170.63	388.08
400.48	556.22	442.46	152.96	344.38	**98**	460.32	639.33	508.57	175.82	395.84
408.49	567.34	451.30	157.58	351.27	**99+**	469.53	652.12	518.74	181.13	403.76

*See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

MONTHLY PREMIUMS*

ZIP CODES: 900-918, 926-928, 944, 946

NON-TOBACCO						TOBACCO				
Plan A WM20	Plan F WM24	Plan G WM25	Plan High G WM36	Plan N WM35	Attained Age	Plan A WM20	Plan F WM24	Plan G WM25	Plan High G WM36	Plan N WM35
391.39	543.60	428.88		336.67	**Thru 64**	449.88	624.83	492.96		386.97
156.56	217.45	171.55	62.76	134.67	**65**	179.96	249.94	197.18	72.14	154.79
156.56	217.45	171.55	62.76	134.67	**66**	179.96	249.94	197.18	72.14	154.79
172.21	239.19	188.70	62.76	148.13	**67**	197.94	274.93	216.90	72.14	170.27
179.45	249.23	197.01	65.28	154.65	**68**	206.26	286.47	226.45	75.04	177.76
186.68	259.28	205.32	67.79	161.17	**69**	214.58	298.03	236.00	77.91	185.26
193.91	269.33	213.61	70.30	167.69	**70**	222.88	309.57	245.53	80.80	192.75
201.14	279.37	221.92	72.80	174.20	**71**	231.20	321.11	255.08	83.68	200.23
208.38	289.42	230.22	75.21	180.72	**72**	239.52	332.67	264.62	86.45	207.72
217.13	301.57	239.89	77.66	188.31	**73**	249.58	346.63	275.74	89.26	216.45
225.88	313.73	249.56	80.31	195.90	**74**	259.63	360.61	286.86	92.31	225.17
234.64	325.88	259.23	82.96	203.50	**75**	269.70	374.58	297.96	95.35	233.90
243.39	338.04	268.90	85.81	211.08	**76**	279.76	388.55	309.08	98.63	242.62
252.13	350.19	278.57	88.68	218.68	**77**	289.81	402.52	320.20	101.93	251.35
261.21	362.80	288.60	91.53	226.55	**78**	300.24	417.01	331.72	105.21	260.40
270.28	375.40	298.62	94.34	234.42	**79**	310.67	431.50	343.24	108.43	269.45
279.38	388.02	308.65	97.20	242.29	**80**	321.13	446.00	354.77	111.73	278.50
288.45	400.62	318.68	100.19	250.16	**81**	331.56	460.48	366.29	115.16	287.54
297.52	413.23	328.71	103.25	258.03	**82**	341.98	474.98	377.83	118.68	296.59
308.24	428.10	340.54	106.39	266.80	**83**	354.29	492.07	391.43	122.29	306.67
318.95	442.98	352.38	109.63	275.59	**84**	366.61	509.17	405.03	126.02	316.77
329.66	457.86	364.21	112.98	284.36	**85**	378.92	526.27	418.64	129.86	326.85
340.37	472.74	376.05	116.41	293.13	**86**	391.23	543.38	432.24	133.81	336.93
351.08	487.62	387.87	119.95	301.90	**87**	403.54	560.48	445.83	137.87	347.01
358.11	497.36	395.64	123.61	307.94	**88**	411.62	571.68	454.76	142.08	353.96
365.26	507.30	403.55	127.37	314.10	**89**	419.84	583.11	463.85	146.40	361.03
372.57	517.46	411.62	131.24	320.38	**90**	428.24	594.78	473.13	150.86	368.26
380.01	527.80	419.85	135.24	326.78	**91**	436.80	606.66	482.59	155.45	375.61
387.62	538.35	428.25	139.34	333.32	**92**	445.54	618.79	492.24	160.17	383.12
395.37	549.13	436.82	143.58	339.98	**93**	454.45	631.19	502.09	165.04	390.79
403.27	560.10	445.56	147.94	346.78	**94**	463.53	643.80	512.14	170.04	398.60
411.34	571.31	454.46	152.43	353.73	**95**	472.81	656.68	522.37	175.21	406.58
419.57	582.73	463.55	157.05	360.80	**96**	482.26	669.81	532.81	180.52	414.71
427.97	594.39	472.82	161.81	368.02	**97**	491.92	683.21	543.47	185.99	423.01
436.52	606.28	482.28	166.73	375.38	**98**	501.75	696.87	554.34	191.64	431.47
445.26	618.41	491.92	171.77	382.89	**99+**	511.79	710.81	565.43	197.43	440.10

*See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

Premium Information
The premium for your policy will change. Because the premium rate is based on your attained age, the premium will increase each year as you age. A premium change for any other reason can occur on any policy renewal date. However, we cannot make such a change unless we make the same change to all policies of this form issued in the same state to persons of the same classification.

Use this outline to compare benefits and premiums among policies.

Read Your Policy Very Carefully
This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

Thirty Day Right to Return Policy
If you find that you are not satisfied with your policy, you may return it to 3300 Mutual of Omaha Plaza, Omaha, NE 68175. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

Policy Replacement
If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Household Premium Discount
You are eligible for a household premium discount if: (a) you reside with your spouse (including civil union/domestic partner) of any age or (b) for the past year you have resided with at least one, but not more than three, other adults who are age 60 or older. The discounted premium will be priced 12% lower than the rates illustrated. The policy's household premium discount will be removed if the other adult or spouse no longer resides with you (other than in the case of his or her death).

Disclosures
The policy may not fully cover all of your medical costs. Neither United World Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details. For additional information concerning policy benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. Call the HICAP toll-free telephone number, 1-800-434-0222, for referral to your local HICAP office. HICAP is a service provided free of charge by the State of California. You may also contact the Consumer Affairs department of the California Department of Insurance after first contacting your agent or the insurance company for resolution of any problems. Mutual of Omaha's toll-free customer service telephone number is shown on the face page of your policy. You can contact the Consumer Affairs department at California Department of Insurance, Consumer Service Division, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP(4357).

Notice
The policy may not fully cover all of your medical costs. United World Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

Complete Answers Are Very Important
When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Exclusions
Exclusions apply to your coverage. Please be sure to review the exclusions in your policy. This policy does not cover Part A benefits for benefit periods that begin while this policy is not in force, and other exclusions apply.

Mutual of Omaha | Underwritten by Mutual of Omaha Insurance Company | 3300 Mutual of Omaha Plaza Omaha, Nebraska 68175

Monthly Rates (Issue Age 19-99)

CALIFORNIA							
ZIP Codes	**Mutual Dental Preferred DNT2**			**Mutual Dental Protection DNT5**			**Vision Rider 0PD1M**
	$1,500	$3,000	$5,000	$1,500	$3,000	$5,000	
922-924,932,933, 936,937,952,953	$61.46	$70.38	$73.45	$33.69	$34.64	$35.28	$8.28
925,934,935,954, 955,959-961	$64.11	$73.41	$76.62	$35.14	$36.13	$36.80	$8.28
900-903,905-921, 926-931,939,940, 945-951,956-958	$66.76	$76.44	$79.78	$36.59	$37.62	$38.32	$8.28
904, 938, 941-944	$69.40	$79.48	$82.95	$38.04	$39.12	$39.84	$8.28

Rates Subject to Change. *As of 07/14/2023*

The applicant will receive the following benefits under the Optional Vision Rider. The applicant must be enrolled in the Mutual of Omaha dental plan to apply.

Up to $50 every calendar year for one eye exam (no waiting period)
Up to $150 every two calendar years for eyeglasses or contact lenses (after a six-month waiting period)

MUTUAL OF OMAHA INSURANCE COMPANY
3300 MUTUAL OF OMAHA PLAZA
OMAHA, NEBRASKA 68175
(402) 342-7600

OUTLINE OF COVERAGE FOR POLICY SERIES DNT2

INDIVIDUAL DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) INSURANCE

THE POLICY PROVIDES LIMITED BENEFIT DENTAL COVERAGE ONLY.
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Limited Benefit Dental-Only Insurance Coverage – This policy is designed to provide you ONLY with limited benefit dental insurance coverage. Coverage is NOT provided for any other diseases or accidents.

Benefits – This is a Preferred Provider Organization (PPO) dental insurance policy that pays benefits for covered dental services provided by in-network and out-of-network dentists. It pays benefits for Diagnostic and Preventive Services, Basic Services, and Major Services. If you incur expense for a covered dental service, we will pay the coinsurance percentage of the allowed amount after you have satisfied the deductible and any applicable waiting period. Benefits payable are limited to any annual maximum benefit and lifetime maximum benefit.

Shown below is a brief summary of the dental benefits we will pay under this policy. For a full list of covered dental services and procedures, please visit our website at www.mutualofomaha.com/individual-dental.

DENTAL BENEFITS SUMMARY

DEDUCTIBLE	AMOUNT
Class I -- Diagnostic & Preventive Services	None
Class II – Basic Services and Class III - Major Services Combined	$50.00
COINSURANCE	**PERCENTAGE PAYABLE**
Class I – Diagnostic & Preventive Services	100%
Class II – Basic Services	80%
Class III – Major Services	20% Day One, 50% After Year One
WAITING PERIOD	**TIME FRAME**
Class I– Diagnostic & Preventive Services	None
Class II– Basic Services	None
Class III– Major Services	None
MAXIMUM BENEFIT	**AMOUNT**
Annual Maximum Benefit per Calendar Year	$1,500, $3,000 or $5,000
Implant Lifetime Maximum Benefit	$3,000

You may obtain dental care for covered dental services from any licensed dentist. No matter which dentist you choose, you will be eligible for some level of benefits for covered dental services. However, when you use an in-network dentist who participates in the PPO network, that dentist has agreed to provide dental care at negotiated fees. For in-network dentists, you will not be responsible for the difference between your dentist's submitted amount and the scheduled fee amount that the dentist has contractually agreed to accept as payment in full. The PPO network used by this policy is DenteMax Plus.

If you select a dentist who does not participate in the PPO network, your out-of-pocket expenses may be greater. For out-of-network dentists, you will be responsible for the difference between your dentist's submitted amount and our payment. The amount we use to

calculate our payment will be the lesser of the dentist's submitted amount or the 80th percentile amount for covered dental services as identified by the Dental Charges Database.

Waiting Period – Covered dental services are subject to the waiting period shown in the above Dental Benefits Summary chart. You must satisfy the waiting period before benefits are paid for these services. The waiting period begins on the policy effective date and is applied once during the lifetime of your policy.

Exclusions -- Your policy pays benefits only for covered dental services. We will not pay benefits for:

(a) first installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered;
(b) services or treatment not prescribed by or under the direct supervision of a dentist;
(c) services or treatment which is experimental or investigational;
(d) services or treatment paid for by worker's compensation or third party liability coverage;
(e) services or treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration hospital or similar person or group;
(f) services or treatment performed prior to the policy effective date;
(g) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
(h) services or treatment which is not dentally necessary or which does not meet generally accepted standards of dental practice;
(i) services or treatment resulting from your failure to comply with professionally prescribed treatment;
(j) telephone consultations;
(k) any charges for failure to keep a scheduled appointment;
(l) any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
(m) fluoride treatments;
(n) services or treatment provided as a result of intentionally self-inflicted injury or illness;
(o) services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
(p) office infection control charges;
(q) charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
(r) state, federal, or territorial taxes on dental services performed;
(s) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
(t) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
(u) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
(v) those dental services which are for specialized procedures and techniques;
(w) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
(x) duplicate, provisional and temporary devices, appliances, and services;
(y) plaque control programs, oral hygiene instruction, and dietary instructions;
(z) services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to:
    1. equilibration;
    2. periodontal splinting;
    3. full mouth rehabilitation and;
    4. restoration for misalignment of teeth;
(aa) gold foil restorations;
(bb) services or treatment for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
(cc) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
(dd) charges by the provider for completing dental forms;
(ee) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
(ff) use of material or home health aids to prevent decay, such as:
    1. toothpaste;
    2. fluoride gels;
    3. dental floss and;
    4. teeth whiteners;
(gg) sealants;
(hh) precision attachments, personalization, precious metal bases and other specialized techniques;

(ii) replacement of dentures that have been:
    1. lost;
    2. stolen or;
    3. misplaced;
(jj) repair of damaged orthodontic appliances;
(kk) replacement of lost or missing appliances;
(ll) fabrication of athletic mouth guard;
(mm) internal bleaching;
(nn) nitrous oxide;
(oo) oral sedation;
(pp) topical medicament carrier;
(qq) orthodontic services, treatment or supplies, including braces and retainers;
(rr) bone grafts when done in connection with:
    1. extractions;
    2. apicoectomies or;
    3. non-covered/non-eligible implants;
(ss) tooth whitening;
(tt) occlusal guards;
(uu) space maintainers;
(vv) services or treatment provided by a member of your immediate family;
(ww) services or treatment received outside of the United States, its possessions or territories, Canada, or Mexico; or
(xx) services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD, TMJD) and related disorders.

Multiple Procedure Limitations – When two or more dental services are submitted and the dental services are considered part of the same service to one another, this policy will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by us. When two or more dental services are submitted on the same day and the dental services are considered mutually exclusive (when one service contradicts the need for the other service), this policy will pay for the service that represents the final treatment as determined by us.

Guaranteed Renewable For Life – The policy is guaranteed renewable for life. We cannot cancel your policy as long as you pay the required premium before the end of each grace period.

Premiums Can Change – We will not increase your policy's premium due to any change in your health. However, we can change premiums if we make the same change to all policies of this form issued to persons of the same class. We will give you the advance notice required by your state prior to any such premium change.

MUTUAL OF OMAHA INSURANCE COMPANY
3300 MUTUAL OF OMAHA PLAZA
OMAHA, NEBRASKA 68175
(402) 342-7600

OUTLINE OF COVERAGE FOR POLICY SERIES DNT5

INDIVIDUAL DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) INSURANCE

THE POLICY PROVIDES LIMITED BENEFIT DENTAL COVERAGE ONLY.
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Limited Benefit Dental-Only Insurance Coverage – This policy is designed to provide you ONLY with limited benefit dental insurance coverage. Coverage is NOT provided for any other diseases or accidents.

Benefits – This is a Preferred Provider Organization (PPO) dental insurance policy that pays benefits for covered dental services provided by in-network and out-of-network dentists. It pays benefits for Diagnostic and Preventive Services, Basic Services, and Major Services. If you incur expense for a covered dental service, we will pay the coinsurance percentage of the allowed amount after you have satisfied the deductible and any applicable waiting period. Benefits payable are limited to any annual maximum benefit and lifetime maximum benefit.

Shown below is a brief summary of the dental benefits we will pay under this policy. For a full list of covered dental services and procedures, please visit our website a www.mutualofomaha.com/individual-dental.

DENTAL BENEFITS SUMMARY

DEDUCTIBLE	AMOUNT
Class I -- Diagnostic & Preventive Services, Class II – Basic Services and Class III – Major Services Combined	$100.00
COINSURANCE	**PERCENTAGE PAYABLE**
Class I – Diagnostic & Preventive Services	100%
Class II – Basic Services	50%
Class III – Major Services	20% Day One, 50% After Year One
WAITING PERIOD	**TIME FRAME**
Class I– Diagnostic & Preventive Services	None
Class II– Basic Services	None
Class III– Major Services	None
MAXIMUM BENEFIT	**AMOUNT**
Annual Maximum Benefit per Calendar Year	$1,500, $3,000 or $5,000
Implant Lifetime Maximum Benefit	$2,000

You may obtain dental care for covered dental services from any licensed dentist. No matter which dentist you choose, you will be eligible for some level of benefits for covered dental services. However, when you use an in-network dentist who participates in the PPO network, that dentist has agreed to provide dental care at negotiated fees. For in-network dentists, you will not be responsible for the difference between your dentist's submitted amount and the scheduled fee amount that the dentist has contractually agreed to accept as payment in full. The PPO network used by this policy is DenteMax Plus.

If you select a dentist who does not participate in the PPO network, your out-of-pocket expenses may be greater. For out-of-network dentists, you will be responsible for the difference between your dentist's submitted amount and our payment. The amount we use to

calculate our payment will be the lesser of the dentist's submitted amount or an amount equal to the lowest prevailing scheduled fee used for in-network dentists in the geographic area.

Waiting Period – Covered dental services are subject to the waiting period shown in the above Dental Benefits Summary chart. You must satisfy the waiting period before benefits are paid for these services. The waiting period begins on the policy effective date and is applied once during the lifetime of your policy.

Exclusions -- Your policy pays benefits only for covered dental services. We will not pay benefits for:

(a) first installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered;
(b) services or treatment not prescribed by or under the direct supervision of a dentist;
(c) services or treatment which is experimental or investigational;
(d) services or treatment paid for by worker's compensation or third party liability coverage;
(e) services or treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration hospital or similar person or group;
(f) services or treatment performed prior to the policy effective date;
(g) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
(h) services or treatment which is not dentally necessary or which does not meet generally accepted standards of dental practice;
(i) services or treatment resulting from your failure to comply with professionally prescribed treatment;
(j) telephone consultations;
(k) any charges for failure to keep a scheduled appointment;
(l) any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
(m) fluoride treatments;
(n) services or treatment provided as a result of intentionally self-inflicted injury or illness;
(o) services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
(p) office infection control charges;
(q) charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
(r) state, federal, or territorial taxes on dental services performed;
(s) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
(t) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
(u) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
(v) those dental services which are for specialized procedures and techniques;
(w) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
(x) duplicate, provisional and temporary devices, appliances, and services;
(y) plaque control programs, oral hygiene instruction, and dietary instructions;
(z) services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to:
    1. equilibration;
    2. periodontal splinting;
    3. full mouth rehabilitation and;
    4. restoration for misalignment of teeth;
(aa) gold foil restorations;
(bb) services or treatment for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
(cc) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
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(gg) sealants;
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(mm) internal bleaching;
(nn) nitrous oxide;
(oo) oral sedation;
(pp) topical medicament carrier;
(qq) orthodontic services, treatment or supplies, including braces and retainers;
(rr) bone grafts when done in connection with:
    1. extractions;
    2. apicoectomies or;
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